TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
SOUTH TEXAS RADIOLOGY GROUP

**Respondent Name**
XL INSURANCE AMERICA INC

**MFDR Tracking Number**
M4-16-1989-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
MARCH 15, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "We originally sent our bills to Corvel Insurance on 06/25/2015. Then we received a returned claim from Corvel. Letter states rendering & referring provider license number not on bill. We mailed a corrected claim. On 11/24/2015 we received an EOB denying our bill based on past filing deadline. We initially mailed our claim to Corvel within the 95 day filing deadline. Now our claims & request for reconsideration are being denied."

**Amount in Dispute:** $27.17

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "On 8/23/2015, the Requestor's bill was returned to them requesting box 17a and box 24j (Exhibit C) be completed as required by rule. A HCP has 95 days from a DOS to submit a complete medical bill. Per rule §133.20(g) *Health care providers may correct and resubmit as anew bill an incomplete bill that has been returned by the insurance carrier.* Finally, the Requestor has included in their MDR packet a copy of a fax confirmation sheet showing they faxed their billing on 8/28/2015 to Corvel. This packet includes a CMS 1500 form with bill date (box 31) of 8/25/15. Corvel did not receive this fax on this date; however, please note that even if Corvel had received the fax – boxes 17a and 24j were still not completed as required. As such, the bill was still incomplete."

**Response Submitted by:** Corvel

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| June 1, 2015 | CPT Code 73120-26 | $13.07 | $0.00 |
| | CPT Code 73110-26 | $14.10 | $0.00 |
| TOTAL | | $27.17 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §133.10, effective April 1, 2014 sets out the requirements for submitting a complete medical bill.
3. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the procedures for submitting a medical bill.
4. 28 Texas Administrative Code §133.240, effective March 20, 2014, sets out the medical bill processing and audit procedures.
5. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - 29, RM2-The time limit for filing claim/bill has expired.
   - RM2-The time limit for filing claim has expired
   - W3-Appeal/Reconsideration.

**Issues**

Does a timely filing issue exist? Is the requestor entitled to reimbursement?

**Findings**

According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "29-The time limit for filing claim/billing has expired."

The requestor wrote, "We originally sent our bills to Corvel Insurance on 06/25/2015. Then we received a returned claim from Corvel. Letter states rendering & referring provider license number not on bill. We mailed a corrected claim."

The respondent contends that reimbursement is not due because "On 8/23/2015, the Requestor's bill was returned to them requesting box 17a and box 24j (Exhibit C) be completed as required by rule. A HCP has 95 days from a DOS to submit a complete medical bill."

A review of the submitted documentation finds the requestor included a copy of a bill dated June 25, 2015 with a Corvel scan date of August 5, 2015.

28 Texas Administrative Code §133.240(a) states, "An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill."

In response to the claim, the respondent wrote the requestor "PLEASE PROVIDE THE FOLLOWING INFORMATION TO THE BILLING: CMS-1500 Box 17a: Referring provider's state license number and name are required when there is a referring doctor listed in CMS-1500/field 17; the billing provider shall enter the '0B' qualifier and license type, license number, and jurisdictional code (for example, 'MDF1234TX')." A review of the submitted bills finds that the June 25, 2015 and August 25, 2015 are missing information in box 17a.

28 Texas Administrative Code §133.10(f)(1)(K), which states, "All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care. (K) referring provider's state license number (CMS-1500/field 17a) is required when there is a referring doctor listed in CMS-1500/field 17; the billing provider shall enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX');."

The Division finds that the requestor did not comply with the requirements of 28 Texas Administrative Code §133.10(f)(1)(K) by leaving 17a blank; therefore, the original bill was incomplete.

28 Texas Administrative Code §133.20(g) states, "Health care providers may correct and resubmit as a new bill

an incomplete bill that has been returned by the insurance carrier."

Based upon the submitted documentation, on October 8, 2015 the requestor corrected and resubmitted the disputed bill.

Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

The disputed date of service is June 1, 2015. A review of the submitted documentation finds that the requestor submitted a completed claim for payment to Corvel on October 8, 2015. This date is 129 days from the date of service.

The Division finds that the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill for the service in dispute in accordance with Texas Labor Code Section §408.027(a).

**Conclusion**

For the reasons stated above, the Division finds that the requestor has forfeited its right to reimbursement. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | 04/07/2016 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.